The term noncommunicable diseases (NCDs) has entered the vocabulary of policy makers, ministries of health, some medical professionals, and health workers: it is time that it now also becomes a by-word for all those working in the stroke field whether as researchers or clinicians. NCDs are a group of diseases, which by definition is noninfectious and nontransmissible (as opposed to communicable diseases). Stroke is part of the core cluster of major NCDs, which include cardiovascular disease, diabetes mellitus, cancer, and chronic pulmonary diseases. Stroke shares risk factors with the other major NCDs, including tobacco use, unhealthy diet, and physical inactivity. Stroke also shares an important principle: these diseases are potentially preventable to a large extent, and highly cost-effective interventions are available for prevention.

The recent Global Burden of Disease (GBD) Study 2010 showed major shifts from communicable diseases toward NCDs from 1990 to 2010 related to the aging population, decreased childhood mortality, changes in cause-of-death composition, and changes in risk factor exposures. There are 16.9 million incident strokes worldwide, twice as many stroke survivors, and 5.9 million deaths from stroke. Overall stroke ranks third among causes of death and disability-adjusted life years, but it ranks first in the Asian regions that have the highest populations in the world. Eighty percent of the NCD burden occurs in low- and middle-income countries. In low- and middle-income countries, strokes occur ≈8 years earlier in life than in high-income regions. Stroke should no longer be regarded as a disease of old age, about two thirds of all prevalent strokes are seen in people <75 years. Thus, the effects of stroke and NCDs are long ranging: NCDs, such as stroke, affect not only the health sector, but also links to poverty (bidirectionally), economic growth, and sustainable development. Current and projected trends in development of NCDs need to be reversed rapidly and strongly by joint efforts.

The United Nations (UN) political declaration on NCDs was adopted in September 2011, being the second time in the history of the UN that the General Assembly addressed a medical topic; the first time was in 2002 with the meeting on HIV/AIDS that subsequently has had a huge effect on the prevention and treatment of this disease. WHO was given the mandate of implementation and monitoring of the UN political declaration on NCDs.

After intense work, that involved WHO member states, relevant UN agencies, many nongovernmental organizations (NGOs), and many other entities, the World Health Assembly adopted the landmark WHO Global Action Plan for Prevention and Control of Noncommunicable Diseases 2013 to 2020 in May 2013 in Geneva. The document is a road map for operationalizing the commitments of the political declaration and demonstrates the willingness of WHO member states to take action to address NCDs.

Linked to the WHO Global Action Plan is a global monitoring framework that includes 25 indicators and a set of 9 voluntary global targets for the prevention and control of NCDs. The overarching target is to reach a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes mellitus, or chronic respiratory diseases. Other targets pertain to behavioral risk factors (harmful use of alcohol, physical inactivity, salt/sodium intake, tobacco use), biological factors (raised blood pressure, diabetes mellitus, and obesity) and national system responses (drug therapy to prevent heart attacks and strokes), and essential NCD medicines and basic technologies to treat major NCDs. Thus, for stroke all major risk factors are included within the targets, including the single most important risk factor—hypertension.

Are the mortality target set for 2025 achievable for stroke? Whereas mortality rates are widely different across countries and regions, substantial reductions in stroke mortality have been seen in many regions for the past decades and in the most recent update of the GBD, stroke mortality rates had significantly decreased from 1990 to 2010. However, no significant change in age-standardized stroke incidence rates was seen indicating that a declining stroke mortality seems to be mainly driven by increased survival after stroke. It is to be hoped that the NCD action plan will affect not only mortality, but also other indices of the global stroke burden.

One appendix to the Global Action Plan describes the close links between the core NCDs and other comorbidities (eg, the interactions among cerebrovascular disease, cognition, and dementia), whereas another appendix lists other recommended country actions (eg, care of acute stroke and rehabilitation in stroke units and anticoagulation for medium- and high-risk nonvalvular atrial fibrillation).

For the Global Action Plan, a Global coordinating mechanism will be formed to coordinate activities of the UN and promote engagement, international cooperation, collaboration, and accountability among all stakeholders. The coordination mechanism will be convened, hosted, and led by the WHO.
In summary, WHO plays a key role in leading the global actions to decrease the epidemic of NCDs, including stroke. The near future will be critically important for current trends to change. There is a need to work collaboratively to reduce the NCD burden, across disease-specific silos, as well as through integrated prevention and treatment efforts. A multistakeholder effort is needed to engage governments, civil society, and the private sector. Stroke scientists and health professionals have an important responsibility to engage in these actions. A global perspective is needed, and information on ongoing actions at WHO should be well known in all specific fields of NCDs, including stroke. Stroke is a prototype for an NCD for which substantial prevention can be achieved through joint action.

Disclosures

None.

Key Words: global • organization • policy • stroke • world • World Health Organization
Organizational Update: World Health Organization
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Stroke. 2014;45:e22-e23; originally published online December 12, 2013;
doi: 10.1161/STROKEAHA.113.003377
Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the
World Wide Web at:
http://stroke.ahajournals.org/content/45/2/e22

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